Report to the Secretary of Defense

HEALTHCARE FOR MILITARY RETIREES TASK GROUP

Report FY05-4

- **Recommendations regarding improvements to the Military Health System and specifically healthcare of military retirees.**

December 2005

Report Documentation Page		*Form Approved* *OMB No. 0704-0188*

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1. REPORT DATE **DEC 2005**	2. REPORT TYPE	3. DATES COVERED **00-00-2005 to 00-00-2005**
4. TITLE AND SUBTITLE **Healthcare for Military Retirees Task Group**		5a. CONTRACT NUMBER
		5b. GRANT NUMBER
		5c. PROGRAM ELEMENT NUMBER
6. AUTHOR(S)		5d. PROJECT NUMBER
		5e. TASK NUMBER
		5f. WORK UNIT NUMBER
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) **Defense Business Board,1155 Defense Pentagon,Washington,DC,20301-1155**		8. PERFORMING ORGANIZATION REPORT NUMBER
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)		10. SPONSOR/MONITOR'S ACRONYM(S)
		11. SPONSOR/MONITOR'S REPORT NUMBER(S)
12. DISTRIBUTION/AVAILABILITY STATEMENT **Approved for public release; distribution unlimited**		
13. SUPPLEMENTARY NOTES		
14. ABSTRACT		
15. SUBJECT TERMS		

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT **Same as Report (SAR)**	18. NUMBER OF PAGES **64**	19a. NAME OF RESPONSIBLE PERSON
a. REPORT **unclassified**	b. ABSTRACT **unclassified**	c. THIS PAGE **unclassified**			

Standard Form 298 (Rev. 8-98)
Prescribed by ANSI Std Z39-18

HEALTHCARE FOR MILITARY RETIREES TASK GROUP REPORT

TASK

In support of the Department's ongoing transformation efforts, and at the request of the Under Secretary of Defense (Personnel & Readiness), and the endorsement of the Under Secretary of Defense (Comptroller), the Defense Business Board (DBB) formed a Task Group "to assess and make recommendations to the Department of Defense (DoD) on how to manage DoD's rising obligation for providing healthcare for retired military personnel and their dependents."

Specifically, the Task Group evaluated and provided this report on strategies and considerations for retiree healthcare obligations. The Task Group focused on eligibility, benefits provided, co-payments and deductibles, premiums, funding and management, and interaction with healthcare benefits provided by private employers.

Terms of Reference for this Task Group provided for:

1. An assessment of the Department's current design and management strategy of its healthcare program(s) for military retirees and their dependents;

2. Examples and recommendations of successful public or private sector transitions in the ways retiree healthcare benefits are funded, managed and operated; and

3. Options and recommendations that the Department of Defense should consider with respect to the future management and funding of its program(s).

PROCESS

The tasks were performed by the following DBB members:

Task Group Chairman: Henry Dreifus
Task Group Members: Denis Bovin, James Haveman, and Herb Shear
Task Group DoD Liaison: Dr. William Winkenwerder (Assistant Secretary
                              of Defense (Health Affairs))
Task Group Executive Secretary: Kelly S. Van Niman (Executive Director)

The Task Group received background briefings and engaged in meetings and discussions with U.S. Government officials, including the Office of the Assistant Secretary of Defense (Health Affairs), the Office of the Under Secretary of Defense (Comptroller), the Office of Management & Budget (OMB), and the Surgeon Generals of the Army, Navy and Air Force. The Task Group also conducted interviews with private sector healthcare industry professionals to gain their insights on current best practices. Additionally, the Task Group reviewed academic and healthcare resources, including those of other Federal agencies, as well as, case studies and publications containing healthcare industry data and private sector best practices examples.

At the Board's July 28, 2005 quarterly meeting, the Task Group on Healthcare for Military Retirees presented its interim findings and recommendations entitled, Part I Final Report (Appendix A). The full Board concurred with the observations, findings and progress of the Task Group.

Part II of the Task Group's final report was delivered at the December 1, 2005 DBB meeting. The DBB debated and discussed the additional recommendations presented by the Task Group and the full board accepted this report in full without changes. (The Part II Final Report is attached as Appendix B.)

RESULTS

The Board concluded the current Defense healthcare framework is unsustainable due to the rapid increase in DoD's healthcare obligations coupled with the increasing cost of healthcare. Research starting with a 1999 Dartmouth College study found that spending more for healthcare doesn't always lead to better health value, and may, in fact, be harmful.

Today, industry best practices place emphasis on wellness, aggressive and early disease detection and prevention, consumer-directed and age-driven healthcare design, and the extensive use of information technology to improve knowledge and service at lower costs. The Board also observed that evidence-based medicine and consumer-driven healthcare are gaining interest, which brings the consumer into the decision making process.

During the Board's December 1, 2005 meeting, the DBB observed that the Department can bring forward innovations and ideas from industry best practices in its own healthcare plan design and delivery, while still providing the best healthcare to the warfighter and its military retirees, and maintaining the promises that were made by Congress and DoD when the current system was developed.

Since Defense Health has many externally driven elements (i.e., Congressional mandates, military retiree interest groups, etc.), the Board concluded that DoD should engage with Congress and other stakeholders to refresh and innovate the plan design and delivery to reflect 21st century industry best practices.

A significant finding was the alarming trend by private industry and state governments to position TRICARE as the primary provider for military retirees under their employ – even offering incentives to retirees to opt out of the employer's plan. Congressional support would be necessary to reverse this trend, for example, to position TRICARE as a secondary provider to "fill the gap" in retirees' coverage.

The Board concluded that DoD must aggressively pursue wellness initiatives and disease management programs by rewarding good behavior (and mandate as necessary). The DBB believes that unifying the medical command structure would streamline health delivery without compromising readiness, and would allow the Department to focus its care for retirees. Furthermore, the Department should invest in health information technology and case management strategies. There are seven specific recommendations as described below.

DETAILED RECOMMENDATIONS

1. *Mitigate 'corporate welfare' through establishing TRICARE parity with industry for retirees:*

   ➢ Index existing client participation to industry deductibles, co-payments, and premiums.

   ➢ Position TRICARE as secondary provider to "fill the gap" for retirees with access to corporate healthcare.

   ➢ Provide individuals with easy-to-use/understand comprehensive health decision tools to optimize medical visits, encourage use of generic pharmaceuticals toward decreasing provider and individual costs.

   ➢ Empower and reward clients to make decisions about their own health (consumer-driven healthcare).

   ➢ Increase the enterprise's flexibility in plan design, management, funding, and delivery of healthcare services for retirees and dependents between military and 3rd party facilities.

   ➢ Incorporate industry best practices in plan design including smoker's policy premiums, health savings accounts (HSA) and other rewards for wellness.

2. *Mirror industry best practices to pursue and mandate early disease detection and life management:*

   ➢ Move clients to defined best evidence-based healthcare path which will concomitantly increase satisfaction, quality and predictability, and lower total overall costs & shift acute treatment toward long-term management.

   ➢ Develop a system-wide data warehouse to track and identify potential risks and schedule patient intervention before, not after disease onset.

➢ Utilize specially trained care managers to proactively attend to/assist high-risk population.

➢ Customize a comprehensive communications strategy to drive participation by all stakeholders – key to achieving cost savings.

3. *Aggressively implement wellness initiatives (exempli gratia):*

➢ Promote smoking cessation incentives for the entire community, not just active duty.

➢ Provide alcohol and substance abuse education and interventions.

➢ Educate and encourage prenatal and early childhood care and early nutrition (improving birth weights, etc.)

➢ Health-for-life diet/nutrition, lifestyle (i.e. health club and exercise) education promoting wellness.

➢ Educate, Empower and Endower (E3) patients to take responsibility to improve their health.

➢ Customize wellness programs to target specific age and risk groups.

4. *Invest in health information technology and case management strategies:*

➢ Focus on patient safety to increase efficiency and reduce medical errors.

➢ Fully deploy and more aggressively implement electronic medical records for the *entire* care delivery infrastructure.

➢ Implement and reward efforts toward better predictive health v. acute treatment.

➢ Provide client with information, education, and resources on alternatives; engage the clients in the healthcare decision process.

➤ Adapt design of healthcare services to clients as they age, including strategies that focus on amounts spent in the last 6 months of life.

❖ Strategic source specific care needs for most effective and appropriate delivery.

5. *Unify the command and authority structure to streamline health decision-making without compromising readiness:*

➤ Eliminate duplication of efforts, reduce costs, and increase efficiencies.

6. *Enhance the cross-agency commitment between HHS, Veterans Affairs and Defense Health:*

➤ Increase integration and intersection points including legislative and medical policy, infrastructures, scale economics and market power (*exempli gratia*: formularies), shared facilities and medical records and other resources.

7. *Outreach to private industry best practice healthcare management efforts, interest groups, resources and initiatives:*

➤ Engage with key stakeholders (including Congress, interest groups, etc.) to increase dialogue to bring through new ideas and best practices to improve outcomes.

➤ Defense Health success is interdependent with private industry success.

CONCLUSION

With current healthcare costs for the Department of Defense at approximately $34.2 billion (FY05) and projected expenditures to exceed $50 billion in less than ten years, it is critical that DoD take steps now to address its healthcare approach to its military and retirees. The Department must be able to concomitantly protect the United States while maintaining its promise made to Service Members and retirees.

Healthcare industry leaders remarked to the DBB's Task Group that DoD is in a unique position to achieve these changes. The private sector has over the past 5 years introduced tremendous innovation to improve the quality of healthcare while reducing costs. Outreaching and finding ways to share and collaborate between the private sector and DoD will allow for military retirees to receive better care and service while fulfilling the obligation that the U.S. Government has to each and every tax-payer. Defense healthcare success is coupled with industry's healthcare success.

Respectfully submitted,

Henry Dreifus

APPENDIX A:

Defense Business Board Report

on

Healthcare for Military Retirees (Part I)

(July 2005)

Task Group
on
Healthcare for Military Retirees

PART I FINAL REPORT
July 2005

DBB Task Group

Henry Dreifus (Task Group Chairman)

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James Haveman

Herb Shear

Kelly Van Niman (DBB Executive Director)

Stephan Smith (DBB Staff Assistant)

DoD Sponsor

Dr. David Chu (Under Secretary of Defense (Personnel & Readiness))

DoD Liaison

Dr. William Winkenwerder (Assistant Secretary of Defense (Health Affairs))

OBJECTIVE

1. Provide an assessment of the Department's current design and management strategy of its healthcare programs for military retirees and their dependents;

2. Provide examples and recommendations of successful public or private sector transitions in the ways retiree healthcare benefits are funded, managed and operated; and

3. Provide options and recommendations that the Department of Defense should consider with respect to the future management and funding of its programs.
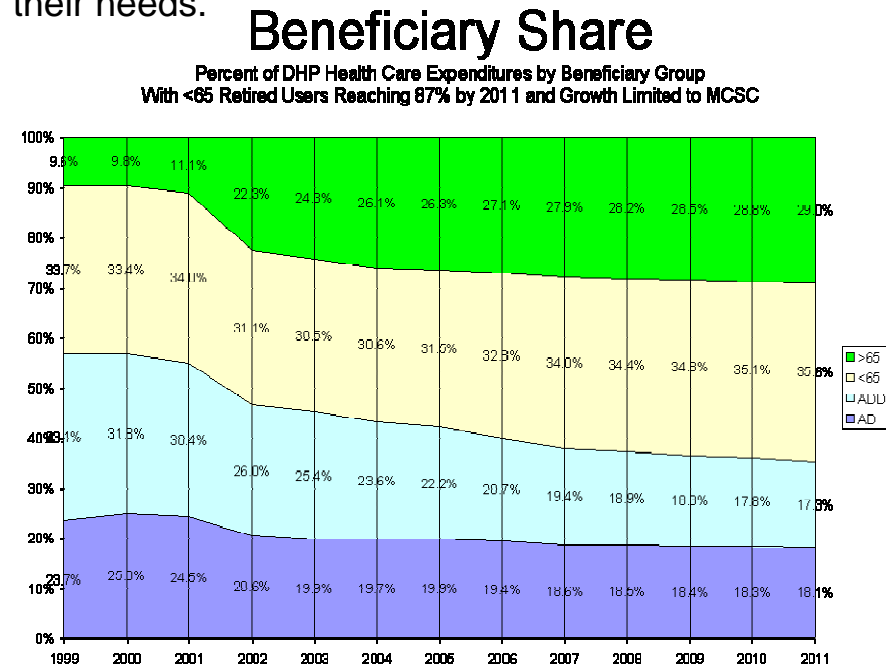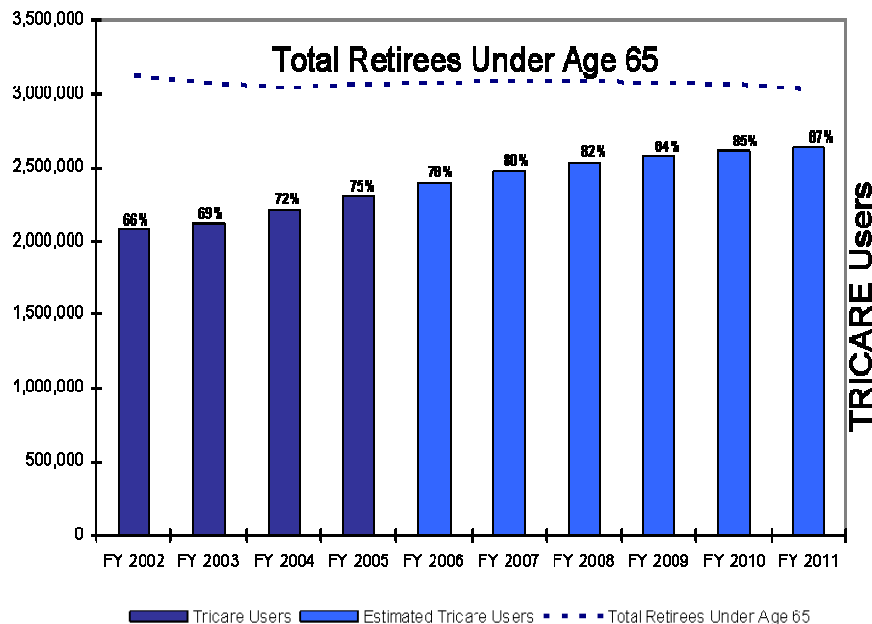
STUDY PROCESS

➢ Background briefing with OASD Health Affairs and OUSD Comptroller staff members

➢ Discussion with Office of Management & Budget (OMB) representatives regarding funding

➢ Private sector best practices research on healthcare

❖ Wellpoint Foundation

❖ Henry Ford Health System

❖ Kaiser Permanente

CURRENT FRAMEWORK IS UN-SUSTAINABLE

➢ 42% of the Defense Health spending is for Active Duty Military and their Family Members
➢ Today 75% of Retiree community under 65 is using TRICARE (all or part), and that rate is projected to be 80% by FY07, 87% by FY11
  ➢ DoD's Future Risk:
    1. Remaining 25% not using TRICARE do begin to use it
    2. Remainder of the 75% currently only using part of TRICARE (i.e. all of it except pharmacy) use TRICARE for ALL of their needs.
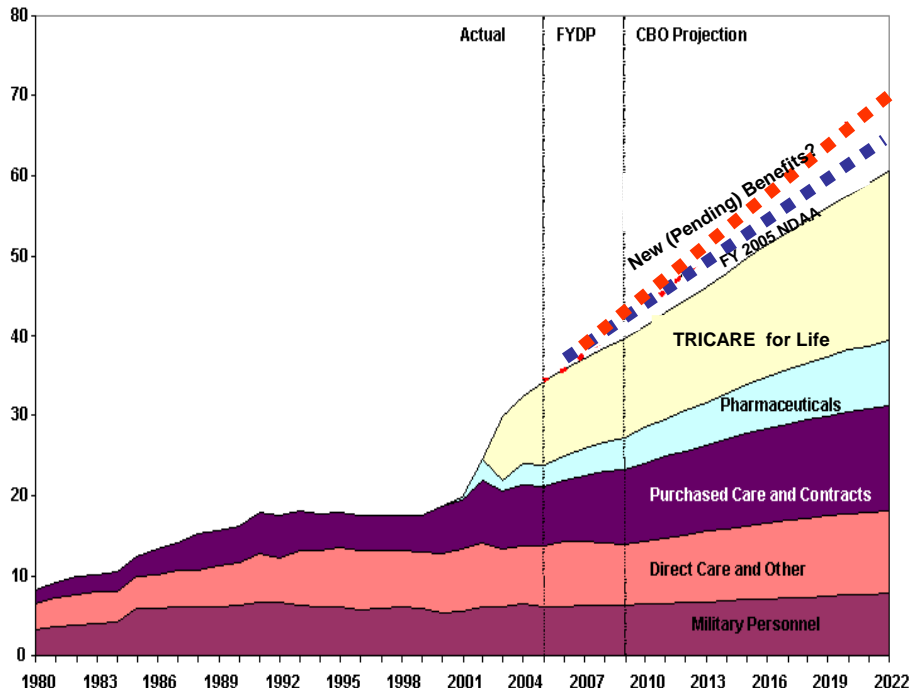

Total Retirees Under Age 65

Beneficiary Share
Percent of DHP Health Care Expenditures by Beneficiary Group
With <65 Retired Users Reaching 87% by 2011 and Growth Limited to MCSC

DEFENSE HEALTH IS AN EXPENSIVE VALUE PROPOSITION

➢ TRICARE is a very good deal for retirees; user fees are de-coupled from the increasing cost equation.

➢ TRICARE is becoming increasingly expensive to the enterprise – Defense Healthcare Budget for FY05 = $34.2 Billion FY05; projected >$50 Billion within 10 years.

(Billions of 2005 dollars)

TRICARE for L

Sizing the Problem

Current Projection with 7% Medical Growth

Cumulative Effect = $73B

FY15 Delta = $17B (28% of medical Budget)

Constrained to 8% of DoD Topline (FY06)

(1) Entire Pharmacy Budget = $14B
(2) Care for all retirees <65 = $19B

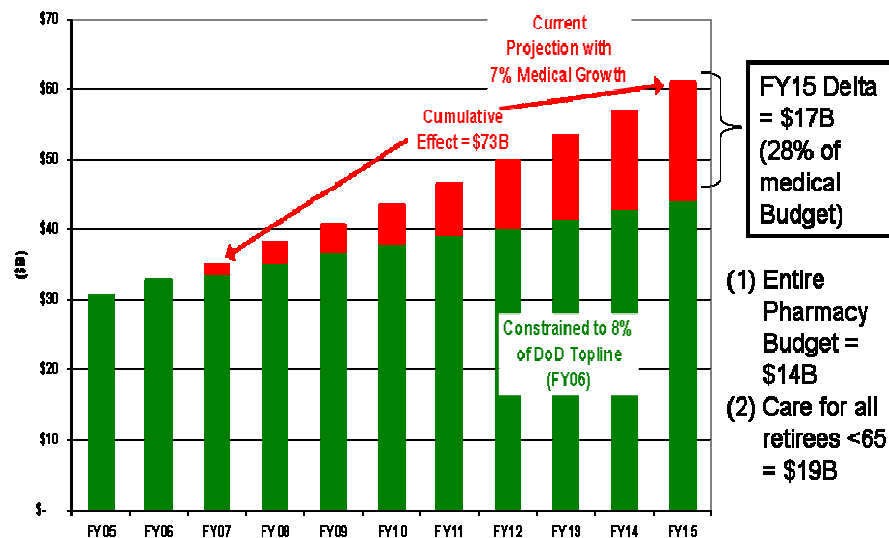**Source: Congressional Budget Office - 2004**

Task Group on
Healthcare for Military Retirees

HEALTHCARE INDUSTRY FINDINGS & TRENDS

➢ Paying more for healthcare doesn't always correlate into better health value (Dartmouth College Study, others).

❖ If you pay more – you're likely getting less health value

➢ Aggressive early condition detection and channeling to disease management lead to lower long-term costs.

➢ Patient electronic medical records and health passports are showing early payoffs.

❖ Applying medical models and predictive tools vs. full annual physicals are a better use of healthcare resources and improve outcome

➢ Age driven healthcare design is key to optimizing and configuring resources mix – especially as population ages.

HEALTHCARE INDUSTRY FINDINGS & TRENDS

➢ US Healthcare is 14% of GDP– rest of industrialized world between 7-10% of GDP. Unless trend is reversed, healthcare may represent 19% of the GDP within 10 years.

➢ Managing Pharmacy costs – driving incentives toward generics and disease-management-driven formularies are key to savings.

➢ Evidence/science based medicine – the future – moving toward continuous quality control versus practice-based medicine.

  ❖ An informed and educated healthcare consumer gets better healthcare at lower costs

➢ Trend is moving away from hospital-driven toward "center's of excellence"-driven healthcare.

➢ Consumer-driven healthcare is gaining interest where the consumer helps to choose the health consideration based on price, quality and potential financial benefit.

LANDSCAPE CONSIDERATIONS

➢ VA and Defense Health have begun initiatives toward working more closely together:

- ❖ On separate, not parallel tracks; VA is a service, Defense Health is a benefit (entitlement).

- ❖ They are evaluating more ways to work toward increasing use of shared facilities and services, and exploiting scale/market power.

➢ Pharmaceuticals are a fast cost growth component – and as the population ages, the use of pharmaceuticals increases dramatically.

➢ Different healthcare services are needed at different ages/stages in lifetime.

➢ Stakeholder education and expectation setting are key ingredients to success.

LANDSCAPE CONSIDERATIONS

➢ Information technology is making a difference: What more can be done? Can it be done faster?

➢ Defense Health is making progress, notwithstanding challenges:

- ❖ Joint Medical Command Study
- ❖ Legislative v. policy constraints

- ❖ Electronic Medical Record
- ❖ Healthy Choices Pilot Program

➢ Defense health plan design is externally driven (i.e. Congressional mandates, military retiree interest groups, etc.), and is decoupled from healthcare cost increases.

➢ Approximately 50% of the peacetime health care benefits are contracted to the private sector. Should this be modified?

PRELIMINARY GUIDANCE FOR CONSIDERATION

1. Mitigate 'corporate welfare' through establishing <u>TRICARE parity</u> with industry for retirees:

    ➢ Index client participation to industry for participant deductibles, co-payments, and premiums

    ➢ Adopt industry practices in plan design including smoker's policy premiums and rewards for wellness

    ➢ Focus on patient safety to increase efficiency and reduce medical errors

2. Mirror industry best practices to <u>pursue and mandate early disease detection and management</u>:

    ➢ Moving clients onto a defined healthcare path concomitantly increases satisfaction, quality and predictability, and lowers total overall costs including shifting acute treatment toward long-term management

PRELIMINARY GUIDANCE FOR CONSIDERATION

3. Aggressively implement and <u>promote wellness initiatives</u> (for example):

  ➢ Smoking cessation incentives for the entire community, not just active duty

  ➢ Alcohol and substance abuse

  ➢ Prenatal and early childhood care and early nutrition (improving birth weights, etc.)

  ➢ Health-for-life Diet/Nutrition, Lifestyle (i.e. health club and exercise); education promoting wellness

4. <u>Invest in health information technology and case management</u> strategies:

  ➢ Fully deploy and implement electronic medical records for entire population and care delivery infrastructure

  ➢ Implement and reward efforts toward better predictive health v. acute treatment

  ➢ Provide client information, education, and resources on alternatives; engage client in healthcare decision process

  ➢ Adapt design of healthcare services to clients as they age, including strategies that focus on amounts spent in the last 12 weeks of life

AREAS FOR FURTHER EVALUATION

➢ Ways to enhance dialogue between Veterans Affairs and Defense Health to achieve increased integration and intersection points including legislative and medical policy, infrastructures, scale economics/market power (i.e. Pharmacy benefits), shared facilities and medical records and resources.

➢ Explore strategies toward improving the command and authority structure for health decision-making for the enterprise without compromising readiness.

➢ Evaluate the merits and challenges toward increasing flexibility of plan design, management and delivery of healthcare services for retirees and dependents between military and 3rd party facilities.

➢ Strategies and approaches to develop tighter linkages to private industry healthcare management efforts and initiatives. Defense health success is interdependent with private industry.

NEXT STEPS

1. Incorporate Board members' observations from the July 28th DBB Meeting.

2. Forward approved recommendations (Part I) to the Secretary through the Deputy Secretary

3. Continue to research private sector examples of transitions in the way retiree healthcare is funded, managed and operated.

4. Develop recommendations on Change Management Strategies – to include education and communications

5. Develop recommendations for an "end-state" vision.

6. Present Part II to the full Board during the December 1, 2005 DBB meeting

7. Work with the OASD Health Affairs to incorporate the DBB's final recommendations into an implementation plan.

DEFENSE BUSINESS BOARD

COMPARISON OF TRICARE TO FEDERAL EMPLOYEE HEALTH

Cost for a Family of 3	TRICARE Prime NADD < 65			FEHBP Kaiser Mid-Atlantic*			TRICARE Standard/ Extra NADD < 65			FEHBP Blue Cross Standard*		
	1999	2004	%Chg	1999	2004	%Chg	1999	2004	%Chg	1999	2004	%Chg
Enrollee Premium	$460	$460	0%	$1,440	$2,260	57%	$0	$0	0%	$1,620	$2,930	81%
Other Out-of-Pocket	$211	$301	43%	$360	$940	161%	$1,341	$1,751	31%	$1,410	$1,510	7%
Total Out-of-Pocket	$671	$769	14%	$1,800	$3,200	78%	$1,341	$1,751	31%	$3,030	$4,440	47%
Government Cost	$5,232	$8,070	54%	$4,170	$6,780	63%	$5,232	$8,070	54%	$4,170	$7,200	73%
Total Cost	$5,903	$8,832	50%	$5,970	$9,980	67%	$6,573	$9,821	49%	$7,200	$11,640	62%
Enrollee Share of Total	11%	9%		30%	32%		20%	18%		42%	38%	
Govt Share of Total	89%	91%		70%	68%		80%	82%		58%	62%	

* Per Checkbook Magazine

BENEFIT CHANGES

Authority that has to be modified to change cost-sharing

Initiative	Regulatory	Legislative
Increase deductibles ■For ADD ■For Retirees & NADD		Amend 10 USC 1079(b)(2)-(3) Amend 10 USC 1086(b)(1)-(2)
Copays for PRIME Enrollees ■For ADD (reintroduce) ■For Retirees & NADD (increase)	Proposed rule change 32 CFR 199.18*	Repeal 10 USC 1097a(e)
Rx copays (retail & mail order) ■For generic & formulary ■For non-formulary	Proposed rule change 32 CFR 199.21	Amend 10 USC 1074g to exceed max copay of 20% for ADD and 25% for Retirees and NADD
Introduce MTF copays (except AD) ■For Rx ■For outpatient visits ■For inpatient admission	Proposed rule change 32 CFR 199.21	Amend several sections of law** Amend several sections of law**
Increase catastrophic caps ■For ADD (index to inflation) ■For Retirees & NADD (increase)		Amend 10 USC 1079(b)(5) Amend 10 USC 1086(b)(4)
Increase PRIME enrollment fees	Proposed rule change 32 CFR 199.18*	
Eliminate TRICARE Triple Option ■For ADD ■For Retirees & NADD	Proposed rule change 32 CFR 199.18	Repeal or amend 10 USC 1097a and several other sections of law

*   However, without legislative change, total out of pocket costs may not exceed those of TRICARE Standard
** There is limited authority under current law, 10 USC 1078, to charge dependents, but statutory changes are needed to exceed minimal amounts, charge retirees, and/or charge ADD in Prime

RECENT KEY BENEFIT LEGISLATION*

FY 2001 (*annual cost $492*)
- Co-payment elimination ($220)
- Catastrophic cap reduction ($91)
- TRICARE PRIME Remote ADFM ($65)
- Medical/Dental benefit expansion ($59)
- Medical record privacy ($30)
- Custodial care ($15)
- Chiropractic health care ($12)

FY 2002 (*annual cost $4,969*)
- TRICARE for Life ($4,903)
- NAS elimination ($38)
- Prosthetics and hearing aids ($23)
- Transitional Health Care ($5)

FY 2003 (*annual cost $54*)
- VA/DoD joint initiatives ($30)
- TRICARE PRIME Remote ADFM expansion ($24)

FY 2004 (*annual cost $400*)
- NDAA 2004 Guard/Reserve TRICARE benefit

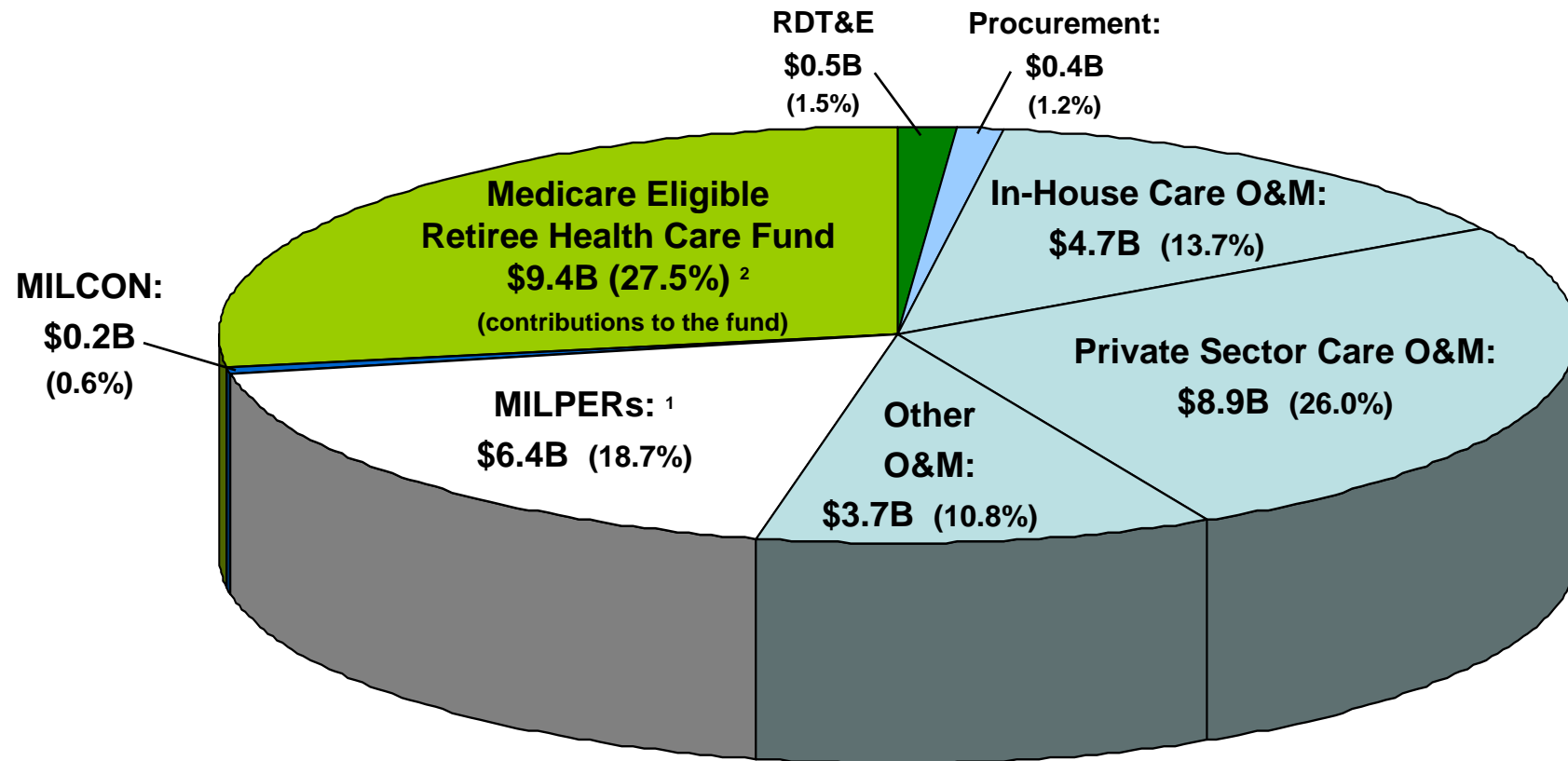**FY 2005 (*initial cost $248, ≈$800 annual future year cost*)**
- NDAA 2005 Guard/Reserve TRICARE benefit

> **Estimated costs in FY 2004 millions of dollars*
>
> *Funded / Unfunded "carve out"*

DoD Health Care Budget For FY 2005

RDT&E
$0.5B
(1.5%)

Procurement:
$0.4B
(1.2%)

Medicare Eligible
Retiree Health Care Fund
$9.4B (27.5%) [2]
(contributions to the fund)

In-House Care O&M:
$4.7B (13.7%)

MILCON:
$0.2B
(0.6%)

Private Sector Care O&M:
$8.9B (26.0%)

MILPERs: [1]
$6.4B (18.7%)

Other
O&M:
$3.7B (10.8%)

Total FY 2005 Budget: $34.2 Billion

1 – Funding for Military Personnel assigned to DoD health care facilities comes directly from Service MILPERs Budgets

2 – Note: DoD also received approximately $6.5 billion in receipts from the Medicare Eligible Retiree Health Care Fund for current year health care costs for Medicare eligible retirees, retiree family members and survivors.

DEFENSE BUSINESS BOARD

GUIDING VALUES FOR AN "END-STATE" VISION

- ➢ Patient Safety
- ➢ Medical "home"
- ➢ Centers of Excellence
- ➢ Disease Management
- ➢ Technology
- ➢ Incentives & Rewards
- ➢ Personal Responsibility

CLOSING THOUGHTS

Failing to address the healthcare crisis would be the worst kind of procrastination… the kind that places our children and grandchildren at risk and threatens the health and global competitiveness of our nations' economy.

> *J. Richard Wagoner, Jr.*
> *Chairman & CEO*
> *General Motors*

A wise man should consider that health is the greatest of human blessings, and learn how by his own thought to derive benefit from his illnesses.

> *Hippocrates*

APPENDIX B:

Defense Business Board Report

on

Healthcare for Military Retirees (Part II)

(December 2005)

Task Group
on
Healthcare for Military Retirees

PART II FINAL REPORT
December 2005

DBB Task Group

Henry Dreifus (Task Group Chairman)

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Stephan Smith (DBB Staff Assistant)

DoD Sponsor

Dr. David Chu (Under Secretary of Defense for Personnel and Readiness)

DoD Liaison

Dr. William Winkenwerder (Assistant Secretary of Defense for Health Affairs)

OBJECTIVES

1. Develop an assessment of the Department's current design and management strategy of its healthcare programs for military retirees and their dependents;

2. Provide examples, insights, and recommendations based on successful public or private sector transitions of retiree healthcare benefit design, funding, management and operations; and

3. Offer options and recommendations for the Department of Defense to consider with respect to the future management and funding of its programs.

STUDY PROCESS

➢ <u>Background briefings and discussions with USG officials</u>

     ❖ Defense Health Affairs

     ❖ Comptroller

     ❖ Office of Management & Budget (OMB)

     ❖ Surgeons Generals of the Army, Navy and Air Force

➢ <u>Private sector best practices interviews from healthcare industry professionals</u>

     ❖ Wellpoint Foundation   ❖ Center for Health Transformation

     ❖ Henry Ford Health System   ❖ Kaiser Permanente

➢ <u>Reviewed academic and healthcare resources, case studies and publications</u>

CURRENT FRAMEWORK IS UN-SUSTAINABLE

➢ Today 58% of Defense Health spending is on Retirees – projected to be 65% by 2011

➢ Today 3 of 4 Retirees under 65 are using TRICARE (all or in part), projected to be 8 of 10 by FY07, and 9 of 10 by FY11

➢ Enterprise Financial Risks:

  1. The 25% not in TRICARE will begin to use it

  2. The portion of the 75% who are currently only using part of TRICARE (i.e. only pharmacy) shift for ALL of their needs to TRICARE.

➢ Defense Healthcare Budget for FY05 = $34.2 Billion; FY06 = $37.1 Billion, projected >$50 Billion within 10 years
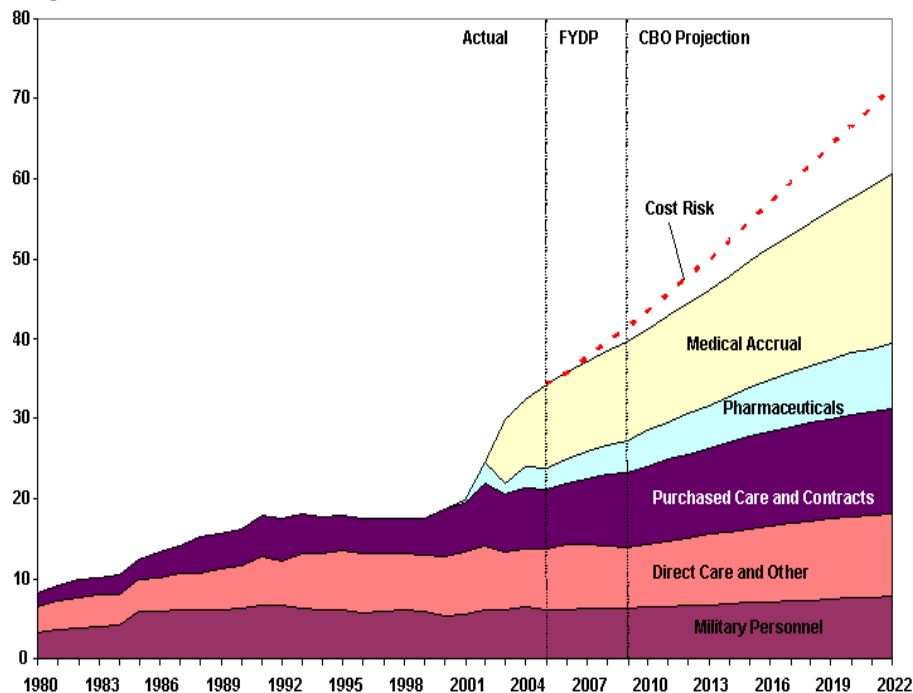
HEALTHCARE INDUSTRY FINDINGS & TRENDS

➢ Paying more for healthcare doesn't necessarily correlate into better health value, and may, in fact, harm patients (Dartmouth College Study, others).

  ❖ If you are paying more – you're probably getting less health value

  ❖ Harvard Medical School & Canadian Institute for Health Information: Overhead accounted for at least 31% of total U.S. health spending in 1999 vice 16.7% in Canada

➢ Aggressive early condition detection and channeling to disease management lead to lower long-term costs.

  ➢ Private sector focusing initiatives on high risk enrollees to mitigate future expenses

  ➢ Medicare data shows that 12% of beneficiaries account for 69% of total spending

➢ Age driven healthcare design is key to optimizing and configuring resources mix – especially as population ages.

HEALTHCARE INDUSTRY FINDINGS & TRENDS

➢ Information Technology, including patient electronic medical records and health passports, are showing early payoffs.

❖ Streamlining the medical supply chain – at all levels through automation

❖ Identification, mitigation and reduction in medical errors

❖ Applying medical models and predictive tools vice full annual physicals are a better use of healthcare resources and improve outcome

➢ US Healthcare is 14% of GDP– rest of industrialized world between 7-10% of GDP. Unless trend is reversed, healthcare may represent 19% of the GDP within 10 years.

➢ Managing Pharmacy costs – key to savings

❖ IT systems used by physicians for delivery of care

❖ Plan incentives are designed to drive doctors/patients toward over-the-counter medicines, generics, and disease-management-driven formularies

HEALTHCARE INDUSTRY FINDINGS & TRENDS

➢ Applying evidence/outcome based medicine – moving toward continuous quality control versus practice-based medicine

 ❖ Objective is to reduce unwarranted regional differences in care and spending

➢ Consumer-driven healthcare is gaining interest where the consumer helps to choose the health consideration based on price, quality and potential financial benefit.

 ❖ An informed and educated healthcare consumer gets better healthcare at lower cost

➢ Industry initiatives to create Centers of Excellence

LANDSCAPE CONSIDERATIONS

➢ VA and Defense Health have initiatives toward working more closely together:

  ❖ Efforts are on separate, not parallel tracks; VA is a service, Defense Health is a benefit (entitlement).

  ❖ In process of evaluating more ways to work toward increasing use of shared facilities and services, and exploiting scale/market power.

➢ Pharmaceuticals are a fast cost growth component – and further, as the population ages, the use of pharmaceuticals increases dramatically.

➢ Different healthcare services are needed at different ages/stages in lifetime.

➢ Stakeholder education and expectation setting are key ingredients to success.

LANDSCAPE CONSIDERATIONS

➢ Information technology is making a difference

 ❖ What more can be done? Can it be done faster?

➢ Defense Health is making progress on many fronts:

 ❖ Joint Medical Command Study ❖ Legislative v. policy constraints

 ❖ Electronic Medical Record ❖ Healthy Choices Pilot Program

➢ Defense health plan design is externally driven (i.e. Congressional mandates, military retiree interest groups, etc.), and is decoupled from healthcare cost increases.

 ❖ Many employers provide incentives to employees who are military retirees to use TRICARE – offers significant savings for the employer, and is not in the spirit of the promise made to the retirees and the tax-payer.

➢ Approximately 50% of the peacetime health care benefits are contracted to the private sector.

RECOMMENDATIONS (1 of 7)

1. **Mitigate 'corporate welfare' through <u>establishing</u> *TRICARE parity* with industry for retirees:**

   ➢ Index existing client participation to industry deductibles, co-payments, and premiums.

   ➢ Position TRICARE as secondary provider to "fill the gap" for retirees with access to corporate healthcare.

   ➢ Provide individuals with easy-to-use/understand comprehensive health decision tools to optimize medical visits, encourage use of generic pharmaceuticals toward decreasing provider and individual costs.

   ➢ Empower and reward clients to make decisions about their own health (consumer-driven health care).

   ➢ Increase the enterprise's flexibility in plan design, management, funding, and delivery of healthcare services for retirees and dependents between military and 3rd party facilities.

   ➢ Incorporate industry best practices in plan design including smoker's policy premiums, health savings accounts (HSA) and other rewards for wellness.

RECOMMENDATIONS (2 of 7)

2. **Mirror industry best practices to <u>pursue and mandate early disease detection and life management</u>:**

➢ Move clients to defined best evidence-based healthcare path which will concomitantly increases satisfaction, quality and predictability, and lower total overall costs & shift acute treatment toward long-term management.

➢ Develop a system-wide data warehouse to track and identify potential risks and schedule patient intervention before, not after disease onset.

➢ Utilize specially trained care managers to proactively attend to/assist high-risk population.

➢ Customize a comprehensive communications strategy to drive participation by all stakeholders – key to achieving cost savings.

RECOMMENDATIONS (3 of 7)

3. Aggressively implement <u>wellness initiatives</u> (exempli gratia):

➢ Promote smoking cessation incentives for the entire community, not just active duty.

➢ Provide alcohol and substance abuse education and interventions.

➢ Educate and encourage prenatal and early childhood care and early nutrition (improving birth weights, etc.)

➢ Health-for-life Diet/Nutrition, Lifestyle (i.e. health club and exercise) education promoting wellness.

➢ Educate, Empower and Endower (E^3) patients to take responsibility to improve their health.

➢ Customize wellness programs to target specific age and risk groups.

RECOMMEDATIONS (4 of 7)

4. **Invest in health information technology and case management strategies:**

➢ Focus on patient safety to increase efficiency and reduce medical errors.

➢ Fully deploy and more aggressively implement electronic medical records for the *entire* care delivery infrastructure.

➢ Implement and reward efforts toward better predictive health v. acute treatment.

➢ Provide client with information, education, and resources on alternatives; engage the clients in the healthcare decision process.

➢ Adapt design of healthcare services to clients as they age, including strategies that focus on amounts spent in the last 6 months of life.

❖ Strategic source specific care needs for most effective and appropriate delivery.

RECOMMENDATIONS (5, 6, 7 of 7)

5. **Unify the command structure and authority** to streamline health decision-making for the enterprise without compromising readiness.

   ❖ Eliminate duplication of efforts, reduce costs, increase efficiencies.

6. **Enhance the cross-agency commitment between** HHS, Veterans Affairs and Defense Health.

   ❖ Increase integration and intersection points including legislative and medical policy, infrastructures, scale economics and market power (*exempli gratia*: formularies), shared facilities and medical records and other resources.

7. **Outreach to private industry** best practice healthcare management efforts, interest groups, resources and initiatives.

   ❖ Engage with key stakeholders (including Congress, interest groups, etc.) to increase dialogue to bring through new ideas and best practices to improve outcomes.
   ❖ Defense health success is interdependent with private industry success.

NEXT STEPS

1. Present Final Report to the full Board during the December 1, 2005 DBB meeting.

2. Present Final Report to Secretary and Deputy Secretary.

3. Work with the OASD Health Affairs to incorporate the DBB's final recommendations into an implementation plan.

4. Board stands ready remain engaged to assist the enterprise in implementing the aforementioned recommendations as a resource to help drive innovation and bring best practices forward.

Task Group
on
Healthcare for Military Retirees

Appendix A:
Additional Charts and Data

COMPARISON OF TRICARE TO FEDERAL EMPLOYEE HEALTH

Cost for a Family of 3	TRICARE Prime NADD < 65			FEHBP Kaiser Mid-Atlantic*			TRICARE Standard/ Extra NADD < 65			FEHBP Blue Cross Standard*		
	1999	2004	%Chg	1999	2004	%Chg	1999	2004	%Chg	1999	2004	%Chg
Enrollee Premium	$460	$460	0%	$1,440	$2,260	57%	$0	$0	0%	$1,620	$2,930	81%
Other Out-of-Pocket	$211	$301	43%	$360	$940	161%	$1,341	$1,751	31%	$1,410	$1,510	7%
Total Out-of-Pocket	$671	$769	14%	$1,800	$3,200	78%	$1,341	$1,751	31%	$3,030	$4,440	47%
Government Cost	$5,232	$8,070	54%	$4,170	$6,780	63%	$5,232	$8,070	54%	$4,170	$7,200	73%
Total Cost	$5,903	$8,832	50%	$5,970	$9,980	67%	$6,573	$9,821	49%	$7,200	$11,640	62%
Enrollee Share of Total	11%	9%		30%	32%		20%	18%		42%	38%	
Govt Share of Total	89%	91%		70%	68%		80%	82%		58%	62%	

Per Checkbook Magazine

BENEFIT CHANGES

Authority that has to be modified to change cost-sharing

Initiative	Regulatory	Legislative
Increase deductibles ■For ADD ■For Retirees & NADD		Amend 10 USC 1079(b)(2)-(3) Amend 10 USC 1086(b)(1)-(2)
Copays for PRIME Enrollees ■For ADD (reintroduce) ■For Retirees & NADD (increase)	Proposed rule change 32 CFR 199.18*	Repeal 10 USC 1097a(e)
Rx copays (retail & mail order) ■For generic & formulary ■For non-formulary	Proposed rule change 32 CFR 199.21	Amend 10 USC 1074g to exceed max copay of 20% for ADD and 25% for Retirees and NADD
Introduce MTF copays (except AD) ■For Rx ■For outpatient visits ■For inpatient admission	Proposed rule change 32 CFR 199.21	Amend several sections of law** Amend several sections of law**
Increase catastrophic caps ■For ADD (index to inflation) ■For Retirees & NADD (increase)		Amend 10 USC 1079(b)(5) Amend 10 USC 1086(b)(4)
Increase PRIME enrollment fees	Proposed rule change 32 CFR 199.18*	
Eliminate TRICARE Triple Option ■For ADD ■For Retirees & NADD	Proposed rule change 32 CFR 199.18	Repeal or amend 10 USC 1097a and several other sections of law

* However, without legislative change, total out of pocket costs may not exceed those of TRICARE Standard

** There is limited authority under current law, 10 USC 1078, to charge dependents, but statutory changes are needed to exceed minimal amounts, charge retirees, and/or charge ADD in Prime

RECENT KEY BENEFIT LEGISLATION*

FY 2001 (*annual cost $492*)
- Co-payment elimination ($220)
- Catastrophic cap reduction ($91)
- TRICARE PRIME Remote ADFM ($65)
- Medical/Dental benefit expansion ($59)
- Medical record privacy ($30)
- Custodial care ($15)
- Chiropractic health care ($12)

FY 2002 (*annual cost $4,969*)
- TRICARE for Life ($4,903)
- NAS elimination ($38)
- Prosthetics and hearing aids ($23)
- Transitional Health Care ($5)

FY 2003 (*annual cost $54*)
- VA/DoD joint initiatives ($30)
- TRICARE PRIME Remote ADFM expansion ($24)

FY 2004 (*annual cost $400*)
- NDAA 2004 Guard/Reserve TRICARE benefit

FY 2005 (*initial cost $248, ≈$800 annual future year cost*)
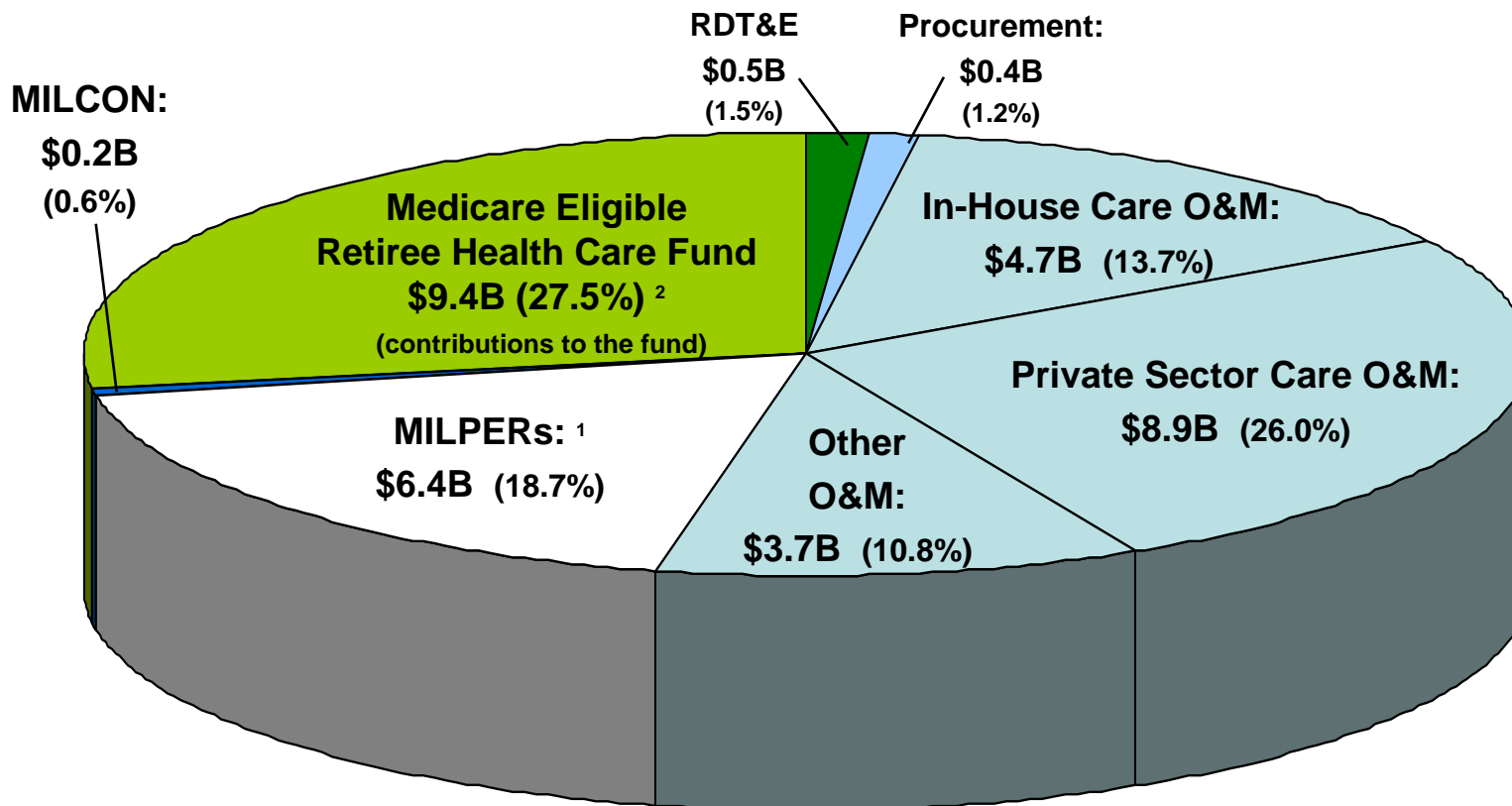- NDAA 2005 Guard/Reserve TRICARE benefit

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*Estimated costs in FY 2004 millions of dollars

Funded / Unfunded "carve out"

Defense Business Board

DEFENSE BUSINESS BOARD

DoD Health Care Budget For FY 2005

RDT&E
$0.5B
(1.5%)

Procurement:
$0.4B
(1.2%)

MILCON:
$0.2B
(0.6%)

Medicare Eligible
Retiree Health Care Fund
$9.4B (27.5%) [2]
(contributions to the fund)

In-House Care O&M:
$4.7B (13.7%)

Private Sector Care O&M:
$8.9B (26.0%)

MILPERs: [1]
$6.4B (18.7%)

Other
O&M:
$3.7B (10.8%)

1. Funding for Military Personnel assigned to DoD health care facilities comes directly from Service MILPERs Budgets

2. DoD also received approximately $6.5 billion in receipts from the Medicare Eligible Retiree Health Care Fund for current year health care costs for Medicare eligible retirees, retiree family members and survivors.

Total FY 2005 Budget: $34.2 Billion

Task Group
on
Healthcare for Military Retirees

Appendix B:
Private Sector Best Practices Success Stories

SUCCESS STORIES
Implementation Of Healthcare Best Practices

➤ Problem:

   o Family health care costs are rising more than 10% per year. Employers and government fund the majority of these costs, but individuals also experiencing rapid increases in their out-of-pocket costs

➤ Solution:

   o Employers/insurers offer individuals access to easy to use/understand self-care/health decision support tools leading to decreases in medical visits (31%) and need for medical services (62%)

➤ Strategies:

   o Provide individuals with easy-to-use/understand comprehensive health decision tools so that will decrease medical visits, encourage use of generic pharmaceutical alternatives and decrease both the providers' and individual's costs

   o Empower individuals to make decisions about their own health (consumer-driven health care)

SUCCESS STORIES
Implementation Of Healthcare Best Practices
Disease Management

➢ Examples:

- o Public-Private Partnership (state-level): patient-centered disease management program that is "guaranteed to save" $33 million over 2 years for the state

- o Company with large numbers of "high risk" employees (specifically truck drivers) doubled their ROI in two years

    - Reduced heart attacks by ~50%, and reduced claim costs by 19.5% (heart attack claims went from 16% to 13.67% of total claim expenditures);

    - Reduced hospital days (36%), emergency room visits (9%) and physician office visits (6%)

➢ Strategies:

- o Develop common IT platform encompassing all aspects of health system – hospitals, physician practices and the health plan

SUCCESS STORIES
Implementation Of Healthcare Best Practices
Disease Management

➤ Strategies (continued)

    o   Develop a system-wide data warehouse to track and prompt patient treatment

    o   Adopt "open-access" and "max care" model for doctor visits

    o   Utilize specially trained care managers to proactively attend to/assist high-risk population

    o   Develop a customized strategy with tactics adapted for company's unique workforce to <u>drive participation</u> *(participation is key to driving pay-offs)*

        •   Identify barriers to participation

SUCCESS STORIES
Implementation Of Healthcare Nest Practices
Wellness Initiatives

➢ Examples:

  o Senior-focused wellness programs for all U.S. Medicare beneficiaries could save an estimated $3B/year

  o Nation-wide targeted wellness program reduced members' high-risk, sedentary behavior by 70% (long-term savings from lower utilization of high-cost services)

  o 300-bed hospital w/10,000 admissions yearly reduced infections by one-third through a hand-hygiene compliance program – potential estimated savings of $2.5M

➢ Strategies:

  o Educate and empower patients to take responsibility to improve their health in order to drive enrollment and participation

  o Customize wellness programs to target your audience

SUCCESS STORIES
Implementation Of Healthcare Best Practices
Information Technology

➢ Examples:

o Regional health care system (24 clinics and 426-bed hospital) that was already pioneering the use of Electronic Medical Records (EMRs) embedded electronic transcription into their EMRs (moving away from professional transcribers) - saved $2M in less than 2 yrs.

o Wireless medication/patient barcode technology reduces medical errors and costs

  • 30-bed medical unit prevented 50 medication errors per 10,000 doses in one month – saving $3 M per year (based on cost of $5,000/patient/medical error as per the American Medical Association)

o Regional health care provider implemented electronic medical records and expanded automation – saving ~$3M - ~$7M in per year

  • Spent $21M over 12 years (system paid for itself within four years)

  • These savings do not include the improvements in patient health and safety, minimizing errors and saving doctors' time

SUCCESS STORIES
Implementation Of Healthcare Best Practices
Information Technology

➢ Examples (continued)

    o   Veterans Affairs:

        • Implementation of electronic medical records has allowed VA to care for 50% more patients today than in 1995, while having its budget increase by only 15%

        • Implementation of a bar code documentation of medication administration at the bedside has resulted in 50% to 75% reduction in the medication error rate at most VA Medical Centers

➢ Strategies:

    o   Store EMRs in single database so all see the same, real-time patient data

        • Involve all clinical users, not only certain groups

    o   Design system to drive cost savings by directing physicians to hospital formulary, recommending alternative more cost-effective therapeutic substitutions

SUCCESS STORIES
Implementation Of Healthcare Best Practices
Information Technology

➢ Strategies (continued):

  o Design system to drive process/cycle time reductions by alerting physicians to product shortages in the pharmacy and suggesting alternatives

  o Design system to interface with other systems, e.g. ICU, radiology, pharmacy, labs, and even the patient's wristband

  o Design a patient-centric health information system (not facility-centric)

SUCCESS STORIES
Implementation Of Healthcare Best Practices
Case Management Strategies

➢ Examples:

   o   End of Life Programs:

- For every $1.00 Medicare spends on Hospice, it saves $1.50, AND patients in Hospice tend to live longer than those who decide not to go on Hospice.

- There are Hospice-like programs in the private sector that receive satisfaction levels of 99% from caregivers and physicians.

- If 5% of the costliest Medicare beneficiaries utilized an end of life program, there'd be an estimated $20B in savings over a five-year period for the U.S. ($4B/year).

➢ Strategies:

   o   Health insurance companies partner with customized care providers who have a core competency in care delivery for a particular audience

   o   Hospitals outsource specific care needs, such as end-of-life programs, to allow most effective and appropriate care to be delivered